

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Advanced Comprehensive Laboratory LLC
d/b/a TopLab
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

AAA Case No.	17-19-1145-0525
Applicant's File No.	00049053
Insurer's Claim File No.	40-02F2-53T
NAIC No.	25178

ARBITRATION AWARD

I, Sandra Adelson, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD**:

Injured Person(s) hereinafter referred to as: the patient

1. Hearing(s) held on 07/01/2021
Declared closed by the arbitrator on 07/01/2021

Joseph Armao, Esq. from Drachman Katz, LLP participated for the Applicant

James Karins, Esq. from James F. Butler & Associates participated for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 2,651.73**, was NOT AMENDED at the oral hearing.
Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The applicant seeks payment for the balance due for a urinalysis drug screen performed on 7/25/19.

The respondent has asserted a fee schedule defense. The respondent was billed \$2,711.83 for drug screening, drug confirmation, and urinalysis performed on 7/25 /19. Respondent issued a partial payment of \$60.10 and denied the balance pursuant to the fee schedule.

4. Findings, Conclusions, and Basis Therefor

The record consisted of claimant's submission, respondent's submission, as well as documents not enumerated within this decision, but which are contained in the case file maintained by the American Arbitration Association. THE ARBITRATOR SHALL BE THE JUDGE OF THE RELEVANCE AND MATERIALITY OF THE EVIDENCE OFFERED pursuant to 11 NYCRR 65-4.5 (o) (1) (Regulation 68-D). The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations. Based on a review of the documentary evidence, this claim is decided as follows:

A presumption of medical necessity attaches to a timely submitted no fault claim. All County Open MRI & Diagnostic Radiology. P.C. v. Travelers Ins. Co., 11 Misc. 3d 131[A], 815 N.Y.S.2d 493 (App.Term 9th & 10th Jud. Dists. 2006). The burden then shifts to the defendant to rebut the presumption of medical necessity. A.B. Medical Services PLLC v. Utica Mut. Ins. Co., 10 Misc 3d 50, 809 N.Y.S.2d 765 (App.Term 2nd & 11th Jud. Dists. 2005); and A Plus Medical, P.C. v. Government Employees Ins. Co., 21 Misc 3d 799, 870 N.Y.S.2d 858 (Civil Ct. Kings Co. 2008).

In order to meet this burden, the defendant must establish the treatment or tests in question were not in accordance with generally accepted medical/professional practice. Delta Medical Supplies, Inc. v. NY Central Mutual Ins. Co., 14 Misc. 3d 1231[A], 836 N.Y.S.2d 492 (Civil Ct. Kings Co. 2007); and CityWide Social Work & Psychological Servs. V. Travelers Indem. Co., 3 Misc 3d 608, 777 N.Y.S.2d 241 (Civil Ct. Kings Co. 2004)

The defendant must prove there is a factual basis and medical rationale for the opinion of the its expert. Prime Psychological Services v. Progressive Cas. Ins. Co., 24 Misc 3d 1244[A], 901 N.Y.S.2d 902, 2009 NY Slip Op 51868[U] (Civil Ct. Richmond Co. 2009); and Nir v. Allstate Ins. Co., 7 Misc 3d 544, 796 N.Y.S.2d 85.

The patient was a then 31-year-old female who was involved and injured in a motor vehicle accident which took place on 6/14/19. The patient came under the treatment of Dr. Margarita Kaganovskaya who prescribed the testing in issue which was performed on 7/25/19.

At issue is whether applicant billed respondent correctly. Applicant billed respondent for the following services rendered on 8/21/19. Applicant billed for the testing in issue as follows:

CPT 80101 x 9: \$194.04

CPT 80102 x 68: \$2,492.88

CPT 81002 x 1: \$6.59

CPT 81003 x 1: \$6.59

CPT 82570 x 1: \$11.73

Respondent's denial established payment in full as billed for CPT 82570, CPT 81002, CPT 81003. Respondent remitted payment of \$35.19 for CPT 80101 and denied any payment for CPT 80102. Respondent's defense is that applicant billed in excess of the fee schedule.

The respondent must come forward with competent evidentiary proof to support its fee schedule defenses. See, *Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co.*, 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). 11 NYCRR 65-3.8(g)(1), in effect as of April 1, 2013, provides that proof of the fact and amount of loss sustained pursuant to Insurance Law section 5106 (a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and(b) and the regulations promulgated thereunder for services rendered by medical providers. Therefore, respondent is not required to preserve a fee schedule defense in a timely denial of claim.

Respondent submitted competent evidentiary proof in support of its defense and submitted a fee audit from James S. Lee, D.C., CPC. Dr. Lee, CPC concluded that the correct reimbursement rate for the services rendered was \$60.10. Specifically, Dr. Lee asserted the following in his fee audit:

"The records indicate that the services were performed outside the State of New York upon a claimant who resides in New York. Per 11 NYCRR 68.6, for services rendered on or after 01/23/18, the applicable reimbursable amount is the lowest of:

- (1) the highest allowance amount under the applicable NY fee schedule;
- (2) the amount charged by the provider; and
- (3) the prevailing fee in the geographic location of the provider.

New York Fee Schedule Analysis

Per 11 NYCRR § 68 and section 5108 of the Insurance Law, the New York State Workers ' Compensation Medical Fee Schedule applies to the claims herein.

While the Workers Compensation fee schedule was updated effective 04/01/19, the increased reimbursement rates are not in effect until 10/01/20 for no-fault providers.

In general, the correct fee for a particular procedure is calculated by multiplying the Relative Value Units (RVU) assigned to the procedure 's CPT code with the applicable Conversion Factor (CF), subject to ground rules.

The highest Conversion Factor comes from Region IV.

The applicable Conversion Factor for Region IV is as follows:

(a) Pathology and Laboratory Codes: \$1.19

New Jersey Fee Schedule Analysis

The prevailing fee at the place of service is the New Jersey PIP fee schedule pursuant to NJAC 11:3-29. Specifically, the physicians' rates for the North Region would apply per NJAC 11:3-29.2 and NJAC 11:3-29.3(a)(2).

Per NJAC 11:3-29.4(g), the fee schedules shall be interpreted in accordance with the Medicare Claims Processing Manual, the NCCI Policy Manual for Medicare services, Modifier 59 Article: Proper Usage Regarding Distinct Procedural Service, and the CPT Assistant.

The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two CPT/HCPCS codes should not be reported together.

- A Correct Coding Modifier Indicator (CCMI) of "0" indicates that there are no modifiers associated with NCCI that are allowed to be used with the code pair.
- A CCMI of "1" indicates that the codes may be reported together only in defined circumstances that are identified on the claim by the use of specific NCCI-associated modifiers, such as modifier 59.
- A CCMI of "9" indicates that an NCCI edit does not apply to the code pair because the edit for the code pair was deleted retroactively.

Per NJAC 11:3-29.4(e), the insurer's limit of liability for any medical expense benefit for any service or equipment not set forth in or not covered by the fee schedules shall be a reasonable amount considering the fee schedule amount for similar services or equipment in the region where the service or equipment was provided.

Where the fee schedule does not contain a reference to similar services or equipment, the insurer's limit of liability for any medical expense benefit for any service or equipment not set forth in the fee schedule shall not exceed the usual, customary and reasonable fee, which may be determined based on national databases of fees, such as those published by FAIR Health, Wasserman, or Optum/Ingenix.

The American Medical Association's CPT Professional states that definitive drug classes (CPT codes 80320 - 80373) are reimbursable once per date of service per category. For example, "to report amphetamine and methamphetamine using any number of definitive procedures, report 80324 once per facility per date of service."

Date of Service	Billed Code	Qty	Billed Amount	Paid Amount	NY Fee	NJ Fee	Amount Explanation
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07/25/19	80101	9	\$194.04	\$35.19	\$35.19	\$102.00	Paragraphs 15, 16
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80102	68		\$2,492.88	\$0.00	\$0.00	\$0.00	Paragraphs 15, 16
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81002	1		\$6.59	\$6.59	\$6.59	\$4.00	Paragraphs 15, 16
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81003	1		\$6.59	\$6.59	\$6.59	\$5.00	Paragraphs 15, 16
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82570	1		\$11.73	\$11.73	\$11.73	\$20.00	Paragraph s 15, 16
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			\$2,711.83	\$60.10	\$60.10	\$131.00	
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Per the New York fee schedule:

a. CPT code 80101 is for " drug screen, qualitative; single drug class method (eg, immunoassay, enzyme assay), each drug class" with a Relative Value of 21.56.

Pathology & Laboratory Ground Rule 12 states:

" When urine drug screening is performed in an office setting using a quick or rapid screening test method utilizing a stick/dip stick, cup or similar device, reimbursement shall be limited to one unit of 80101 for a single drug class or 80104 for two or more drug classes regardless of the number of drug classes tested or reported per date."

Per the AMA' s CPT Assistant (Dec 2010), qualitative screen analysis that tests for multiple drug classes is appropriately billed under CPT code 80104. The CPT Assistant article does not limit the application of this code to a particular type of setting where the procedure is performed, ie an office setting. Instead, it states that CPT code 80104 represents the method for screening multiple drug classes in a single procedure.

The records show that the qualitative screen was performed by AU680, which is a non-chromatographic method. It is reimbursable at one unit of CPT code 80104, which is for "drug screen, qualitative; multiple drug classes other than chromatographic method , each procedure," with a Relative Value of 29.57. $CF \$1.19 \times RVU 29.57 = \35.19 .

b. CPT code 81002 is for " urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen , any number of these constituents; non-automated , without microscopy" with a Relative Value of 5.54. It is reimbursable at $CF \$1.19 \times RVU 5.54 = \6.59 .

c. CPT code 81003 is for " urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy" with a Relative Value of 5.54. It is reimbursable at $CF \$1.19 \times RVU 5.54 = \6.59 .

d. CPT code 82570 is for "creatinine; other source" with a Relative Value of 9.86. It is reimbursable at $CF \$1.19 \times RVU 9.86 = \11.73 .

e. CPT code 80102 is for " drug confirmation , each procedure" with a Relative Value of 30.81.

Per the AMA' s CPT Assistant (Mar 2000), this code is used for each procedure that are necessary for confirmation . Confirmation is required for drug classes that are positive or inconsistently negative in a multi-drug class screen.

The pathology report contains no positive or inconsistent negative results. As such, this code is not reimbursable.

Per the New Jersey fee schedule:

The billed pathology codes are not listed in the New Jersey fee schedule, Appendix, Exhibit 1, Physicians and ASC Fee Schedules.

Per NJAC 11:3-29.4(e), the insurer ' s limit of liability shall be a reasonable amount considering the fee schedule amount for similar services.

FAIR Health provides two amounts per CPT code, an out-of-network / uninsured price and an in-network price. The New Jersey rule instructs to allow payment at a reasonable amount, considering the fee schedule amount for similar services or equipment in the region where the service or equipment was provided. The in-network price is therefore the appropriate price to consider.

a. CPT codes 80100-80104 were replaced by CPT codes 80300-80304 effective 01/01/15, which were then replaced by CPT codes 80305-80307 effective 01/01/17. CPT code 80307 for "drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers and mass spectrometry either with or without chromatography , includes sample validationwhen performed, per date of service" has a FAIR Health in-network price of \$102.00 at the provider' s location and is reimbursable once at that amount.

b. CPT code 81002 has a FAIR Health in-network price of \$4.00 at the provider' s location and is reimbursable once at that amount.

c. CPT code 81003 has a FAIR Health in-network price of \$5.00 at the provider' s location and is reimbursable once at that amount.

d. CPT code 82570 has a FAIR Health in-network price of \$20.00 at the provider' s location and is reimbursable once at that amount.

e. As stated above, per the AMA' s CPT Assistant (Mar 2000), CPT code 80102 is used for each procedure that requires confirmation due to a positive or inconsistently negative finding in a multi-drug class screen.

The pathology report contains no positive or inconsistent negative results. As such, this code is not reimbursable.

Conclusion:

f. The claim totaling \$2,711.83 exceeds the permissible fee schedule. The lowest and applicable fee amount is the New York fee schedule. The correct allowable amount is \$60.10. The carrier issued prior payment of \$60.10. No additional payment is due.

Applicant did not submit a fee audit or professional expert opinion to support its billing or refute Dr. Lee's fee coder analysis and audit. Applicant therefore provided insufficient evidence to refute the coder affidavit of Dr. Lee, C.P.C.

In reviewing and comparing the evidence presented, I am persuaded by Dr. Lee, CPC's fee audit affidavit. Applicant at the hearing failed to make adequate and persuasive arguments to dispute this affidavit and the submission for applicant did not include a coder affidavit. Therefore, applicant has not presented an expert opinion to refute Dr. Lee's contentions and arguments regarding the services in issue. I am also constrained to find that the coder affidavit of Dr. Lee, C.P.C. was detailed, logical and persuasive.

On the specific facts of this claim and evidence submitted, this claim is denied.

5. Optional imposition of administrative costs on Applicant.
Applicable for arbitration requests filed on and after March 1, 2002.

I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. I find as follows with regard to the policy issues before me:

- ☐ The policy was not in force on the date of the accident
- ☐ The applicant was excluded under policy conditions or exclusions
- ☐ The applicant violated policy conditions, resulting in exclusion from coverage
- ☐ The applicant was not an "eligible injured person"
- ☐ The conditions for MVAIC eligibility were not met
- ☐ The injured person was not a "qualified person" (under the MVAIC)
- ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
- ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York

SS :

County of Suffolk

I, Sandra Adelson, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

07/28/2021

(Dated)

Sandra Adelson

IMPORTANT NOTICE

This award is payable within 30 calendar days of the date of transmittal of award to parties.

This award is final and binding unless modified or vacated by a master arbitrator. Insurance Department Regulation No. 68 (11 NYCRR 65-4.10) contains time limits and grounds upon which this award may be appealed to a master arbitrator. An appeal to a master arbitrator must be made within 21 days after the mailing of this award. All insurers have copies of the regulation. Applicants may obtain a copy from the Insurance Department.

ELECTRONIC SIGNATURE

Document Name: Final Award Form

Unique Modria Document ID:
1d8fc2bfc19debe2f54fd264dfa23265

Electronically Signed

Your name: Sandra Adelson
Signed on: 07/28/2021